



SOUTH DAKOTA BOARD OF NURSING
SOUTH DAKOTA DEPARTMENT OF HEALTH
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ FAX: 362-2768 ♦ www.state.sd.us/doh/nursing

RN EXAMINATION APPLICATION

FIRST-TIME TESTERS: There are 3 separate forms and fees that you must submit to start the examination process:

1. Board of Nursing [Application](#) for RN Licensure by Examination + \$100 fee payable to the Board.
2. NCLEX® Examination Registration through [Pearson](#) Professional Testing + \$200 fee to Pearson.

Please refer to your NCLEX® Candidate Bulletin for payment instructions. **Do not send the NCLEX® fee** to the Board of Nursing; the Board will not forward any fees on your behalf.

- Criminal Background Check: \$44 fee payable to DCI
 1. Pursuant to SDCL 36-9-97, [ARSD 20:48:03:01:01](#), [ARSD 20:48:05:01](#), [ARSD 20:48:03:01](#), [ARSD 20:48:03:07](#), and [ARSD 20:48:03:08](#) each applicant for initial licensure is required to submit a full set of fingerprints with completed application to obtain a state and federal criminal background check.
 2. If you download an application from the website www.state.sd.us/doh/nursing and submit the completed application to the South Dakota Board of Nursing, fingerprint cards will be mailed to you.
 3. The fingerprint cards you receive from the SDBON **must** be the cards you use for fingerprints, since specific agency data are pre-printed on them.
 4. Contact your local law enforcement agency for fingerprinting.
 5. Send to the SD Board of Nursing office your completed fingerprint cards and a separate check or money order for \$44 payable to: South Dakota Division of Criminal Investigation (DCI).
 6. Your application will not be processed and/or temporary license will **not** be issued until your completed application **and** fingerprint cards are received.
 7. You will **not** receive a permanent license until the fingerprint results from the Federal Bureau of Investigation (FBI) are received by the Board, approximately 1-2 weeks.
 8. Cards will be rejected if bent, folded, tampered with, stained, smeared, or stapled. If rejected, you will be notified to resubmit your cards.

An application is null one year from the date it was accepted by the Board. All fees are non-refundable.

NAME / ADDRESS CHANGES: If your [name changes](#), submit legal proof, such as a copy of a marriage certificate or court order, to the Board; the Board will update your NCLEX® registration to reflect the new name. If a change occurs in your address, phone, email or other information after you submit your application, send written notification to the [Board](#) as soon as possible. Official notification of exam results and licensure will be sent to the address provided on the NCLEX® registration unless you submit written notification of an alternate address.

REQUEST FOR ACCOMMODATIONS: Candidates with disabilities requiring modification to their examination must provide written notification to the Board *prior to* NCLEX® Examination Registration. Your letter must address the specific testing accommodations you require. You must also arrange for:

- A letter from your nursing school indicating what modifications were granted by the program
- A letter from an appropriate professional providing specific identification of a disability that would require accommodations

ELIGIBILITY REQUIREMENTS: The Board will determine eligibility after the applicant has submitted:

- [Application](#) for Licensure by Examination and all fees
- Legal documentation (as required)
- [Certificate of Nursing Education](#) completed by your nursing program
- Official transcripts from your school's Registrar (N/A for SD nursing program graduates, whose nursing program director will furnish the Certificate of Nursing Education on your behalf)
- NCLEX® Registration through [Pearson](#) Professional Testing (as verified by the SD Board of Nursing)

TESTING PERIOD: When you have met requirements, the Board will declare your eligibility and an Authorization to Test (ATT) will be issued by Pearson Testing. The ATT is valid for 90 days; no extension will be granted. Once you have received your ATT, you must schedule the exam date with Pearson Professional Testing, following instructions provided with the ATT notification. **The Board of Nursing does not schedule exams.** Please provide an email address with your registration to allow for rapid delivery of the ATT following the Board's declaration of eligibility. If you require a review of your application, please contact the [Board](#).

OFFICIAL NOTIFICATION: Ten business days after you take the NCLEX®, results will be mailed to you by the Board. If you passed, your nursing license will also be mailed. If you did not pass, you will receive a "[Request to Reapply](#)" and diagnostic profile to help you understand your performance on the NCLEX®.

TEMPORARY PERMIT [APPLICATION](#): It is illegal to practice nursing in South Dakota without a valid license or Temporary Permit; there is no provision in law to use the title "graduate nurse." A Temporary Permit holder must use the title Registered Nurse Applicant (RN App). A Temporary Permit is available only for a **first-time** NCLEX® writer who has fulfilled eligibility requirements and received an ATT from Pearson Testing. A Temporary Permit will not be issued until you have submitted the completed Temporary Permit Application, the completed fingerprint cards for the criminal background check, and respective fees.

The Temporary Permit must be presented to your employer, and is issued for use in one specific facility only. Limitations on the scope of practice for RN Applicants are noted on the Permit; please review them carefully. Temporary Permits are not renewable; they are valid for 90 days, or until written notification of NCLEX® testing results is received by the applicant, whichever comes first. Failure on the NCLEX® terminates the right to practice nursing; applicants failing the NCLEX® must return the Temporary Permit to the Board of Nursing.

EXAMINATION PREPARATION: NCSBN has extensive information on the NCLEX® exam at www.ncsbn.org. NCSBN also sponsors an online review course for NCLEX® candidates at www.learningext.com.



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APPLICATION FEE
\$100

APPLICATION FOR REGISTERED NURSE LICENSURE BY EXAMINATION

Because South Dakota is a member of the Nurse Licensure Compact, you are not eligible for nurse licensure in South Dakota if your primary state of residence is another Compact State. Please see www.ncsbn.org for more information or for a current list of Compact States.

Type or print clearly in black ink ■ Provide all information ■ Incomplete applications are returned ■ Do not use initials or abbreviations

LAST NAME		FIRST NAME		MIDDLE NAME	
MAIDEN NAME		OTHER LAST NAME(S)		BIRTH DATE: MONTH/DAY/YEAR	
ADDRESS				EMAIL	
CITY		STATE		ZIP	
SS#:		US CITIZEN: <input type="checkbox"/> YES <input type="checkbox"/> NO		TELEPHONE () () ()	
		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		OTHER TELEPHONE () () ()	
ETHNICITY: <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other					
HIGH SCHOOL: NAME, CITY, AND STATE				<input type="checkbox"/> DIPLOMA – YEAR:	
				<input type="checkbox"/> GED – YEAR:	
SCHOOL OF NURSING: NAME, CITY, AND STATE				DEGREE TYPE: <input type="checkbox"/> DIPLOMA <input type="checkbox"/> ASSOCIATE <input type="checkbox"/> BACCALAUREATE	
DATE ENTERED:		DATE COMPLETED:		OR ANTICIPATED DATE OF COMPLETION:	
Have you ever applied for Registered Nurse licensure by examination in another state?		<input type="checkbox"/> YES <input type="checkbox"/> NO		If “YES,” where? Please explain.	
Have you ever taken the NCLEX-RN® or other nurse licensure examination in any state?		<input type="checkbox"/> YES <input type="checkbox"/> NO		If “YES,” where? Please explain.	
DISCIPLINARY INFORMATION					
1. Have you ever been convicted, pled guilty or no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communications with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.					<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Is there any pending criminal prosecution against you which would constitute a felony?					<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?					<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?					<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?					<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?					<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Have you ever been treated for abuse or misuse of any alcohol or chemical substance?					<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?					<input type="checkbox"/> YES <input type="checkbox"/> NO
9. Do you currently owe child support arrearages in the amount of \$1,000 or more?					<input type="checkbox"/> YES <input type="checkbox"/> NO
For 2-9 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and events. You must also send ALL supporting applicable documents.					
DECLARATION OF PRIMARY STATE OF RESIDENCE – AND – AFFIDAVIT					
<input type="checkbox"/> I declare that my primary state of residence (where I hold a driver's license, pay taxes, and/or vote) is: _____ This is my “home state” under the Nurse Licensure Compact and is my “declared fixed permanent and principal home for legal purposes.” - OR - <input type="checkbox"/> I am employed by the federal government, and so am not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence. Name of employer: _____ I further declare and affirm under penalties of perjury that this application for nurse licensure in South Dakota has been examined by me, and, to the best of my knowledge and belief, is in all things true and correct. Applicant Signature: _____ Date: _____					



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APPLICATION FEE
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REQUEST TO **REAPPLY** FOR REGISTERED NURSE LICENSURE BY EXAMINATION

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LAST NAME		FIRST NAME		MIDDLE NAME	
MAIDEN NAME		OTHER LAST NAME(S)		BIRTH DATE: MONTH/DAY/YEAR	
ADDRESS				EMAIL	
CITY		STATE	ZIP	TELEPHONE ()	
SS#:	US CITIZEN: <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	OTHER TELEPHONE ()	
ETHNICITY: <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other					
HIGH SCHOOL: NAME, CITY, AND STATE				<input type="checkbox"/> DIPLOMA – YEAR:	
				<input type="checkbox"/> GED – YEAR:	
SCHOOL OF NURSING: NAME, CITY, AND STATE				DEGREE TYPE : <input type="checkbox"/> DIPLOMA <input type="checkbox"/> ASSOCIATE <input type="checkbox"/> BACCALAUREATE <input type="checkbox"/> OTHER:	
DATE ENTERED:	DATE COMPLETED:	OR ANTICIPATED DATE OF COMPLETION:			
Have you ever applied for Registered Nurse licensure by examination in another state?		<input type="checkbox"/> YES <input type="checkbox"/> NO	If “YES,” where? Please explain.		
How many times / where have you taken the NCLEX-RN® or other nurse licensure examination?					
DISCIPLINARY INFORMATION					
1. Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communications with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.					<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Is there any pending criminal prosecution against you which would constitute a felony?					<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?					<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?					<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?					<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?					<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Have you ever been treated for abuse or misuse of any alcohol or chemical substance?					<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?					<input type="checkbox"/> YES <input type="checkbox"/> NO
9. Do you currently owe child support arrearages in the amount of \$1,000 or more?					<input type="checkbox"/> YES <input type="checkbox"/> NO
For 2-9 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and events. You must also send ALL supporting applicable documents.					
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<input type="checkbox"/> I declare that my primary state of residence (where I hold a driver's license, pay taxes, and/or vote) is: _____ This is my “home state” under the Nurse Licensure Compact and is my “declared fixed permanent and principal home for legal purposes.” - OR - <input type="checkbox"/> I am employed by the federal government, and so am not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence. Name of employer: _____ I further declare and affirm under penalties of perjury that this application for nurse licensure in South Dakota has been examined by me, and, to the best of my knowledge and belief, is in all things true and correct. Applicant Signature: _____ Date: _____					

CERTIFICATE OF NURSING EDUCATION

**This certificate is to be filled in with black ink and signed by the
Director of the School of Nursing
from which the applicant graduated.**

Graduate: _____ SS# _____

Nursing Program: _____
Name of Nursing Program City State

Admission Date ____/____/____

Completion / Graduation Date ____/____/____

**The program included theory
and clinical experience in:**

- ☐ Adult Health Nursing
- ☐ Maternal Child Health Nursing
- ☐ Geriatric Nursing
- ☐ Mental Health Nursing
- ☐ Community Health Nursing
- ☐ Other

Was the nursing program state-approved
when the applicant graduated? ☐ YES ☐ NO

Was high school completion verified? ☐ YES ☐ NO

If YES, by what means?

- ☐ High School Diploma
- ☐ GED

Degree granted:

- ☐ Diploma/Certificate in Practical Nursing
- ☐ Associate Degree in Nursing
- ☐ Diploma in Nursing
- ☐ Baccalaureate in Nursing
- ☐ Other: _____

*I hereby certify that the foregoing statements are
correct as shown on the records of the above
named individual on file in the school of nursing.
I recommend her (him) for examination and
State Licensure.*

**PLACE
SCHOOL SEAL
HERE**

Signature of Director or Dean of Program of Nursing

Date

FOR BOARD USE ONLY

License Number _____

Date Licensed _____

Date(s) Written _____

Please send this completed form to SOUTH DAKOTA BOARD OF NURSING
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